

OFFICE OF VITAL STATISTICS		State of Delaware (107)		DEPARTMENT OF HEALTH AND SOCIAL SERVICES		STATE FILE NUMBER	
LOCAL REG NO.		1. DECEDENT'S NAME (FIRST, MIDDLE, LAST)		2. SEX		3. DATE OF DEATH (MO., DAY, YR)	
		ANDREW J. TALENTI		MALE		OCTOBER 21, 2006	
4. SOCIAL SECURITY NO.		5A. AGE (YRS)		5B. UNDER 1 YEAR MONTHS DAYS		5C. UNDER 1 DAY HOURS MINUTES	
		41					
6. DATE OF BIRTH (MO., DAY, YR)		7. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY)					
04/12/1965		Pittsburgh, PA					
8. WAS DECEDENT EVER IN U.S. ARMED FORCES?		9. ANATOMICAL GIFT		10A. PLACE OF DEATH (CHECK ONLY ONE, SEE INSTRUCTIONS ON OTHER SIDE)		10B. CITY, TOWN, OR LOCATION OF DEATH	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<input type="checkbox"/> CONSENT GRANTED <input checked="" type="checkbox"/> NOT GRANTED		<input type="checkbox"/> HOSPITAL <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> DQA <input type="checkbox"/> OTHER NURSING HOME <input checked="" type="checkbox"/> RESIDENCE <input type="checkbox"/> OTHER (SPECIFY)			
10C. FACILITY NAME (IF NOT INSTITUTION GIVE STREET AND NUMBER)		10D. CITY, TOWN, OR LOCATION OF DEATH		10E. COUNTY OF DEATH			
		NC					
11. MARITAL STATUS — MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPEC.)		12. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME)		13A. DECEDENT'S USUAL OCCUPATION (KIND OF WORK DURING MOST OF WORKING LIFE. DO NOT USE RETIRED)		13B. KIND OF BUSINESS/INDUSTRY	
Never Married		N/A		Correctional Officer		State	
14A. RESIDENCE — STATE		14B. COUNTY		14C. CITY, TOWN, OR LOCATION		14D. STREET AND NUMBER	
Delaware		New Castle					
14E. INSIDE CITY LIMITS? (YES OR NO)		14F. ZIP CODE		15. WAS DECEDENT OF HISPANIC ORIGIN? (SPECIFY NO OR YES. SPECIFY CUBAN, MEXICAN, PUERTO RICAN, ETC.)		16. RACE — AMERICAN INDIAN, BLACK, WHITE, ETC. (SPECIFY)	
No				<input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		WHITE	
17. DECEDENT'S EDUCATION (SPECIFY ONLY HIGHEST GRADE COMPLETED)		18. FATHER'S NAME (FIRST, MIDDLE, LAST)		19. MOTHER'S NAME (FIRST, MIDDLE, MAIDEN SURNAME)			
12							
20A. INFORMANT'S NAME (TYPEPRINT)		20B. MAILING ADDRESS (STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE, ZIP CODE)					
21A. METHOD OF DISPOSITION		21B. PLACE OF DISPOSITION (NAME OF CEMETERY, CREMATORY, OR OTHER PLACE)		21C. LOCATION (CITY, TOWN, STATE)			
<input type="checkbox"/> BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL FROM STATE <input type="checkbox"/> DONATION <input type="checkbox"/> OTHER (SPECIFY)		Philadelphia Crematory		Philadelphia, PA			
22A. SIGNATURE OF FUNERAL DIRECTOR		22B. LICENSE NUMBER (OF LICENSE)		22C. NAME AND ADDRESS OF FACILITY			
Robert J. Smith		K1-000057		Beeson Funeral Home of Newark 2053 Pulaski Hwy, Newark, DE			
24. REGISTRAR'S SIGNATURE		25. DATE FILED (MO., DAY, YR)		26. LICENSE NUMBER		27. DATE SIGNED (MO., DAY, YR)	
Debra H. H. H.		OCT 27 2006		C100076		10/22/06	
28. TIME OF DEATH		29. DATE PRONOUNCED DEAD (MO., DAY, YR)		30. WAS CASE REFERRED TO MEDICAL EXAMINER? (YES OR NO)			
1615		10/21/06		YES			
30A. CERTIFIER (CHECK ONLY ONE)		30B. SIGNATURE AND TITLE OF CERTIFIER		30C. LICENSE NUMBER		30D. DATE SIGNED (MO., DAY, YR)	
<input type="checkbox"/> CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 26) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.		DEPUTY CHIEF MEDICAL EXAMINER		C10004375		OCTOBER 23, 2006	
<input type="checkbox"/> PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying the cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.							
<input checked="" type="checkbox"/> MEDICAL EXAMINER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.							
31. NAME AND ADDRESS OF CERTIFIER WHO COMPLETED CAUSE OF DEATH (ITEM 40) (TYPEPRINT)		32. DATE OF INJURY (MO., DAY, YR)		33. INJURY AT WORK?		34. DESCRIBE HOW INJURY OCCURRED	
ADRIENNE SEKOLA-PERLMAN 200 S. ADAMS STREET, WILMINGTON, DE 19801		FOUND 10/21/2006		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		FOUND DEAD IN BED.	
35. TIME OF INJURY		36. PLACE OF INJURY (AT HOME, PARK, STREET, FACTORY, OFFICE BUILDING, ETC. (SPECIFY))		37. LOCATION (STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE)			
FOUND 4:00		RESIDENCE.					
38. PART I DO NOT ENTER THE MODE OF DYING SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE PER EACH LINE.		39. PART II OTHER SIGNIFICANT CONDITIONS— CONTRIBUTING TO CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (FINAL DISEASE, INJURY OR CONDITION THAT IN YOUR OPINION CAUSED THE DEATH)		(A) SUBDURAL HEMATOMA					
SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (DISEASE OR INJURY WHICH INITIATED EVENTS RESULTING IN DEATH) LAST		DUE TO (B)					
		DUE TO (C)					
		DUE TO (D)					

TO HOSPITAL OR PHYSICIAN — DELAWARE LAW
REQUIRES THAT THE DEATH CERTIFICATE BE
EXECUTED WITHIN 72 HOURS AFTER DEATH